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MCCRACKEN REST HOME	203 MCCRACKEN STREET WAYNESVILLE, NC 28786

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D 000	Initial Comments The Adult Care Licensure Section and the Haywood County Department of Social Services conducted an annual and follow-up survey on 10/02/19 to 10/03/19.	D 000		
D 124	10A NCAC 13F .0402 Qualifications Of Administrator-In-Charge 10A NCAC 13F .0402 Qualifications Of Administrator-In-Charge The administrator-in-charge, who is responsible to the administrator for carrying out the program in an adult care home in the absence of the administrator, shall meet the following requirements: (1) be 21 years or older; (2) be a high school graduate or certified under the G.E.D. program or have passed an alternative examination established by the Department; (3) have six months training or experience related to management or supervision in long term care or health care settings or be a licensed health professional, licensed nursing home administrator or certified assisted living administrator; and (4) earn 12 hours a year of continuing education credits related to the management of adult care homes or care of aged and disabled persons. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure the Administrator-In-Charge (AIC) completed 12 hours of continuing education credits (CEU's) related to the management of an adult care home in the past 12 months. The findings are:	D 124		

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D 124	Continued From page 1 Review of the AIC's educational training records revealed: -There was documentation for 3 CEU's obtained on 04/18/18 for NC State Infection Control Course. -There was documentation for 1 CEU obtained on 06/21/18 for OSHA and Chemical Hazard Communication. -There was documentation for 1 CEU obtained on 06/21/18 for Resident Rights. -There was no documentation in the record for additional CEU's. Interview with the Administrator on 10/03/19 at 5:00pm revealed: -The AIC was hired 01/01/16. -The AIC oversaw daily operations of the facility when she was not at the facility. -The AIC was responsible for ensuring CEU's were completed. -She did not know that the AIC did not have enough CEU's for 2018. -She did not have any additional documentation of CEU's for the AIC. -The AIC's personnel record had not been reviewed before, so he did not file additional CEU's into the personnel record.	D 124		
D 131	10A NCAC 13F .0406(a) Test For Tuberculosis 10A NCAC 13F .0406 Test For Tuberculosis (a) Upon employment or living in an adult care home, the administrator and all other staff and any live-in non-residents shall be tested for tuberculosis disease in compliance with control measures adopted by the Commission for Health Services as specified in 10A NCAC 41A .0205 including subsequent amendments and editions.	D 131		

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D 131	Continued From page 2 Copies of the rule are available at no charge by contacting the Department of Health and Human Services Tuberculosis Control Program, 1902 Mail Service Center, Raleigh, NC 27699-1902. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure 1 of 3 sampled staff (Staff A) was tested for tuberculosis upon hire. The findings are: Review of Staff A's (Admjinistrator-In-Charge (AIC)/Business Office Manager (BOM) personnel record revealed: -Staff A was hired on 01/01/16. -There was documentation of a tuberculosis (TB) skin test administered on 12/18/16, no results were documented. -There was no documentation of a second TB skin test administered. Interview with the Administrator on 10/03/19 at 5:00pm revealed: -Staff A was hired 01/01/16. -Staff A oversaw daily operations of the facility when she was not at the facility. -Staff A worked as a medication aide (MA) when there was not enough staff to cover shifts. -She considered Staff A as part of administration and did not know that he had to have a TB skin test.	D 131		
D 139	10A NCAC 13F .0407(a)(7) Other Staff Qualifications 10A NCAC 13F .0407 Other Staff Qualifications (a) Each staff person at an adult care home shall:	D 139		

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D 139	Continued From page 3 (7) have a criminal background check in accordance with G.S. 114-19.10 and 131D-40; This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure 1 of 3 sampled staff (Staff A) had a criminal background check completed prior to hire. The findings are: Review of Staff A's, Administrator-In-Charge (AIC)/Business Office Manager (BOM), personnel record revealed: -Staff A was hired on 01/01/16. -There was no documentation of a criminal background check for Staff A, prior to his hire date 01/01/16. Interview with the Administrator on 10/03/19 at 5:00pm revealed: -Staff A was hired on 01/01/16. -Staff A oversaw daily operations of the facility when she was not at the facility. -Staff A was responsible for ensuring criminal background checks were completed. -Staff A worked as a medication aide (MA) when there was not enough staff to cover shifts. -She did not have documentation of a criminal background check for Staff A.	D 139		
D 167	10A NCAC 13F .0507 Training On Cardio-Pulmonary Resuscitation 10A NCAC 13F .0507 Training On Cardio-Pulmonary Resuscitation Each adult care home shall have at least one staff person on the premises at all times who has completed within the last 24 months a course on	D 167		

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cardio-pulmonary resuscitation and choking management, including the Heimlich maneuver, provided by the American Heart Association, American Red Cross, National Safety Council, American Safety and Health Institute or Medic First Aid, or by a trainer with documented certification as a trainer on these procedures from one of these organizations. The staff person trained according to this Rule shall have access at all times in the facility to a one-way valve pocket mask for use in performing cardio-pulmonary resuscitation.

This Rule is not met as evidenced by:
TYPE B VIOLATION

Based on record reviews and interviews, the facility failed to ensure at least one staff member was on the premises at all times who had completed within the last 24 months a course on Cardio-Pulmonary Resuscitation (CPR) and choking management for 2 of 3 sampled staff (Staff B and C) for 2 of 10 shifts sampled for the week of 09/29/19 to 10/03/19.

The findings are:

1. Review of Staff B's, medication aide (MA), personnel file revealed:
-The hire date for Staff B was 08/31/19.
-There was no documentation Staff B had completed a course on CPR in the past 24 months.

Review of the staffing schedule for the week of 09/29/19 to 10/03/19 revealed:
-Staff B had worked 3 of the 5 days from 7:00pm to 7:00am.
-There was no staff scheduled on the

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7:00pm-7:00am shift who had been trained on CPR for 2 shifts on 09/30/19 and 10/02/19.

Attempted telephone interview with Staff B on 10/03/19 at 1:42pm was unsuccessful.

Interview with the Administrator on 10/03/19 at 3:57pm revealed:
-She required MAs/supervisors and personal care aides (PCA) to be CPR certified.
-Staff B had worked at the facility previously, had her CPR certification, and was rehired 08/31/19.
-She did not know Staff B's CPR certification had expired.
-She did not have documentation of Staff B's expired CPR.
-She was aware at least one staff for each shift must be CPR certified.

2. Review of Staff C's, Personal Care Aide (PCA), personnel file revealed:
-There was no hire date provided for Staff C.
-There was no documentation Staff C had completed a course on CPR in the past 24 months.

Review of the staffing schedule for the week of 09/29/19 to 10/03/19 revealed:
-Staff C had worked 2 shifts from 7:00pm-7:00am on 09/30/19 and 10/02/19.
-There was no staff scheduled on the 7:00pm-7:00am shift who had been trained on CPR for 2 shifts on 09/30/19 and 10/02/19.

Interview with the Administrator on 10/03/19 at 3:57pm revealed:
-She required MAs/supervisors and personal care aides (PCA) to be CPR certified.
-She was aware at least one staff for each shift must be CPR certified.

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D 167	Continued From page 6 -Staff C was recently hired and had not completed his CPR certification. The facility failed to ensure there was at least one staff on duty at the facility who had completed a course on CPR and choking management within the last 24 months. The facility's failure was detrimental to the health and safety of the residents in the event of an emergency requiring CPR, which constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 10/03/19 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED NOVEMBER 17, 2019.	D 167		
D 234	10A NCAC 13F .0703(a) Tuberculosis Test, Medical Exam & Immunizatio 10A NCAC 13F .0703 Tuberculosis Test, Medical Examination & Immunizations (a) Upon admission to an adult care home, each resident shall be tested for tuberculosis disease in compliance with the control measures adopted by the Commission for Health Services as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. Copies of the rule are available at no charge by contacting the Department of Health and Human Services, Tuberculosis Control Program, 1902 Mail Service Center, Raleigh, North Carolina 27699-1902. This Rule is not met as evidenced by:	D 234		

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Based on record reviews and interviews, the facility failed to assure 1 of 3 sampled residents (Resident #2) was tested for tuberculosis (TB) disease upon admission.

The findings are:

Review of Resident #2's current FL2 dated 08/22/19 revealed diagnoses of diabetes, hypertension, history of cerebrovascular accident, and coronary artery disease.

Review of Resident #2's Resident Register revealed the resident was admitted on 08/16/19.

Review of Resident #2's record revealed:
-There was results from an abdominal 2 view and chest 1 view X-ray in the record dated 08/15/19.
-There X-ray was result for pleura was "no effusion seen."
-The chest 1 view X-ray was not read specifically for TB disease.
-In handwriting out beside the no effusion seen "TB Neg" was written in.
-The "TB Neg" was not signed, initialed, or dated.

Interview with the Administrator on 10/02/19 at 4:20pm revealed:
-The emergency department wanted the facility to admit Resident #2 on 08/15/19.
-She told the emergency department she needed a TB test before she could admit Resident #2 to the facility.
-The chest X-ray on 08/15/19 was what the emergency department provided her for the TB test.
-The handwritten "TB Neg" was written on the chest X-ray result when she had received it from the emergency department.
-She did not have any prior TB skin tests for the

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D 234	Continued From page 8 resident. Telephone interview with a representative from the local hospital medical records department on 10/03/19 at 8:44am revealed: -The handwritten note "TB Neg" on the Resident #2's chest X-ray on 08/15/19 did not appear on the copy medical records received from the emergency department. -Reviewing all of Resident #2's chest X-ray results from 2012 to 10/03/19, there had not been a chest X-ray which had been read specifically for TB. -If one of the emergency department staff had made a handwritten note on the resident's medical record, the entry should have been signed or initialed and dated by the person who hand wrote the entry.	D 234		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures.	D 358		

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This Rule is not met as evidenced by:
TYPE B VIOLATION

Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered and in accordance with the facility's policies for 1 of 3 sampled residents (Resident #2) including errors in anticoagulation medication and insulin.

The findings are:

Review of Resident #2's current FL2 dated 08/22/19 revealed:
-Diagnoses included diabetes, hypertension, history of cerebrovascular accident, and coronary artery disease.
-The resident was documented as ambulatory and continent of bladder and bowel.

Review of Resident #2's Resident Register revealed the resident was admitted on 08/16/19.

a. Review of Resident #2's current FL2 dated 08/22/19 revealed there was an order for warfarin sodium (used to prevent blood clots) 5mg 1 tablet once daily.

Review of Resident #2's Nurse Practitioner's order dated 08/23/19 revealed:
-There was an order for Xarelto (used to prevent blood clots) 15mg 1 tablet daily with the evening meal for 21 days then increase to 20mg daily with the evening meal.
-There was an order to discontinue the warfarin sodium when the Xarelto was available.

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Review of Resident #2's August 2019 electronic Medication Administration Record (eMAR) revealed:
-There was an entry for warfarin sodium 5mg once daily scheduled at 5:00pm.
-The warfarin sodium was documented as administered daily from 08/16/19 to 08/23/19.
-There was an entry for Xarelto 15mg once daily scheduled at 5:00pm.
-The Xarelto 15mg was documented as administered daily from 08/24/19 to 08/31/19.

Review of Resident #2's Nurse Practitioner's order dated 09/12/19 revealed:
-There was a signed refill authorization for warfarin sodium 5mg once daily.
-The authorization gave permission to refill the warfarin sodium for the current refill plus 11 additional refills.

Review of Resident #2's verbal order from the Nurse Practitioner dated 09/25/19 revealed an order to hold the warfarin sodium until 09/26/19.

Review of Resident #2's verbal order from the Nurse Practitioner dated 09/26/19 revealed an order to discontinue the warfarin sodium.

Review of Resident #2's September 2019 eMAR revealed:
-There was an entry for Xarelto 15mg once daily scheduled at 5:00pm
-The Xarelto 15 mg was documented as administered daily from 09/01/19 to 09/13/19.
-There was an entry for warfarin sodium 5mg once daily scheduled at 5:00pm.
-The warfarin sodium was documented as administered once daily from 09/13/19 to 09/24/19.
-There was an entry for Xarelto 20mg once daily

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scheduled at 5:00pm.
-The Xarelto 20mg was documented as administered daily from 09/14/19 to 09/30/19.

Observation of Resident #2's medications on hand on 10/02/19 at 2:51pm revealed:
-There was one bubble pack of Xarelto 20mg tablets with 30 tablets in the pack.
-The label directions were for Xarelto 20mg 1 tablet once daily.
-There was no warfarin sodium available for administration.

Interview with the Administrator on 10/02/19 at 12:00pm revealed:
-Resident #2 was administered both warfarin sodium and Xarelto daily for a period of time.
-The pharmacy had not entered the warfarin to expire on the eMAR.
-The facility staff had "picked up on it" and notified the Nurse Practitioner on 09/25/19.
-The Nurse Practitioner (NP) had discontinued the warfarin sodium on 09/26/19.

Telephone interview with a representative from the contracted pharmacy on 10/02/19 at 3:29pm revealed:
-The pharmacy had received the order to start Xarelto 15mg and discontinue warfarin sodium when the Xarelto was available on 08/23/19.
-The Xarelto order was entered on the eMAR and the pharmacy dispensed Xarelto 15mg 21 tablets to the facility on 08/23/19 for Resident #2.
-The pharmacy dispensed Xarelto 20mg on 09/14/19 (9 tablets), 09/23/19 (9 tablets), and 09/28/19 (30 tablets).
-The pharmacy had put the note on the eMAR to discontinue the warfarin sodium, however it never got discontinued.
-The pharmacy dispensed warfarin sodium 5mg

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on 08/15/19 (8 tablets) and 09/12/19 (15 tablets).
-"Maybe we were waiting to make sure they got the Xarelto first."
-Xarelto and warfarin sodium were both used to stop clots and dissolve clots.
-Receiving Xarelto and warfarin sodium at the same time increased Resident #2's risk of bleeding and bruising.

Interview with Resident #2's NP on 10/03/19 at 9:25am revealed:
-Resident #2 received warfarin sodium for a history of cerebrovascular accident and coronary artery disease.
-The Xarelto was ordered as a replacement for the warfarin sodium.
-Resident #2 had a history of falls and it was "easier on him and the facility" not to have to do the routine blood monitoring required with warfarin use.
-The facility staff had notified her when they found they had administered warfarin sodium and Xarelto at the same time.
-She had seen Resident #2 and got the warfarin discontinued.
-The biggest risk to Resident #2 having received warfarin sodium and Xarelto at the same time was bleeding.
-When she had assessed Resident #2 on 09/26/19, she had not found any bruising or signs of bleeding.

Interview with a medication aide (MA) on 10/03/19 at 10:02am revealed:
-When staff found they had administered warfarin sodium and Xarelto to Resident #2 at the same time, they had notified the NP and received an order to hold the warfarin sodium.
-Staff then notified the contracted pharmacy.
-Then, the NP discontinued the warfarin sodium.

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D 358	Continued From page 13 -The discontinue order for the warfarin was sent to the pharmacy on the Xarelto order. -The warfarin was stopped and they started the Xarelto as it was ordered. -Then, the pharmacy sent out a refill authorization for the warfarin sodium on 09/12/19 and the NP signed it. -The refill authorization was faxed to the pharmacy and the pharmacy restarted the warfarin order in the eMAR and "I approved it." -She did not know Xarelto and warfarin sodium should not be administered at the same time. -Resident #2 was administered "both until it was caught" on 09/25/19. -"The pharmacy caught it and told me." -She then reported it to the Administrator and the Administrator had reported it to Resident #2's NP on 09/26/19. Interview with the Administrator on 10/03/19 at 4:45pm revealed: -The refill request for Resident #2's warfarin sodium had been sent automatically by the pharmacy. -One of her staff had placed the refill request in the NP's folder. -A medication aide had questioned giving the warfarin sodium and Xarelto during one evening medication pass and had called her to question if the medications should be administered together. -She told the medication aide to hold the warfarin sodium on 09/25/19 until she could speak with the NP on 09/26/19. b. Review of Resident #2's FL2 dated 08/15/19 revealed: -There was a computer generated order for Levemir (long acting insulin used to control elevated blood sugar levels) 100u/ml per sliding scale.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL044046	A. BUILDING: _____ B. WING _____	R-C 10/03/2019

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D 358	Continued From page 14 -There was a handwritten note for regular insulin sliding scale with parameters of 200-250=2 units, 251-300=4 units, 301-350=6 units, 351-400=8 units and call physician. Review of Resident #2's Nurse Practitioner's (NP) order dated 08/20/19 revealed: -There was an order for Levemir 20 units daily in the morning. -There was a handwritten entry to use Novolog (a fast acting insulin used to lower elevated blood sugar levels) before meals and at bedtime per sliding scale with parameters of 201-250=2u, 251-300=4u, 301-350=6u, 351-400=8u, 401-450=10u, and 451-500=12 u and call primary care provider. Review of Resident #2's NP order dated 08/29/19 revealed the Levemir was increased to 22 units daily in the morning. Review of Resident #2's August 2019 electronic Medication Administration Record (eMAR) revealed: -There was an entry for Levemir 100u/ml sliding scale 200-250=2u, 251-300=4u, 301-350=6u, 351-400=8u and call physician scheduled at 8:00am, 12:00pm, 5:30pm, and 8:00pm. -From 08/16/19 to 08/20/19, Levemir was documented as administered per sliding scale for 16 occurrences out of 16 opportunities with a fingerstick blood sugar (FSBS) range of 194-476. -There was an entry for Levemir 20 units once daily in the morning scheduled at 8:00am. -There was an entry for Levemir 22 units once daily in the morning scheduled at 8:00am. -From 08/21/19 to 08/29/19, Levemir 20 units was documented as administered daily at 8:00am. -From 08/30/19 to 08/31/19, Levemir 22 units was documented as administered daily at 8:00am.	D 358		

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D 358	Continued From page 15 Interview with a medication aide on 10/03/19 at 10:02am revealed: -They had "trouble" with Resident #2's insulin upon admission. -The resident was admitted from a local emergency department on a Friday. -The orders on the FL2 were for Levemir to be administered per sliding scale. -She did not remember seeing the handwritten regular insulin per sliding scale order on the FL2 dated 08/15/19. -"We were only giving him Levemir per sliding scale." -They were going by the admission orders received from the local emergency department until the resident could be seen by the facility's primary care provider to be admitted to her care on 08/19/19. Telephone interview with a representative from the contracted pharmacy on 10/03/19 at 11:02am revealed: -They had received an order for Levemir to be given per sliding scale on the FL2 dated 08/15/19. -They had entered the handwritten regular insulin sliding scale on the FL2 dated 08/15/19 into the eMAR as the scale for staff to use for the Levemir. -On 08/20/19, they received an order to change the Levemir to 20u once daily in the morning and received a new order for Novolog (short acting blood sugar control) per sliding scale. Interview with the Administrator on 10/03/19 at 4:45pm revealed: -Staff had notified her and the emergency department on 08/16/19 there were no parameters on the Levemir sliding scale order. -The emergency department responded by faxing	D 358		

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D 358	Continued From page 16 back the FL2 dated 08/15/19 with a handwritten scale for regular insulin sliding scale. -The staff took that to mean the Levemir was to be given sliding scale with that scale because there was not an order for regular insulin. Interview with Resident #2's NP on 10/03/19 at 9:25am revealed: -Resident #2 had come from the hospital with an order for Levemir per sliding scale. -Resident #2 had gotten such a small amount of Levemir that "it kinda acted like a regular insulin." -The NP had been on vacation and the facility staff had tried to contact the on call service for clarification of the insulin, however the on call service did not return the call. -The NP clarified the order as soon as she returned to the facility. The facility failed to ensure medication orders were clarified timely for Resident #2 related to errors administering medications for anticoagulation and insulin. This failure resulted in Resident #2 being administered two anticoagulants for 11 days resulting in increased risk of bleeding; receiving a long acting insulin per sliding scale resulting in elevated blood sugars of 197 to 476 for 5 days. This failure was detrimental to the health, safety, and welfare of the resident and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 10/03/19 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED NOVEMBER 17, 2019.	D 358		

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D 451	Continued From page 17	D 451		
D 451	10A NCAC 13F .1212(a) Reporting of Accidents and Incidents 10A NCAC 13F .1212 Reporting of Accidents and Incidents (a) An adult care home shall notify the county department of social services of any accident or incident resulting in resident death or any accident or incident resulting in injury to a resident requiring referral for emergency medical evaluation, hospitalization, or medical treatment other than first aid. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to report to the County Department of Social Services two falls for 2 of 2 sampled residents (Residents #1 and #2), which required referral for emergency medical evaluation. The findings are: 1. Review of Resident #2's current FL2 dated 08/22/19 revealed diagnoses included diabetes, hypertension, history of cerebrovascular accident, and coronary artery disease. Interview with Resident #2 on 10/02/19 at 11:42am revealed: -He had recently fallen. -He had scraped the skin on the back of his head during the fall. -He had received treatment for the skin abrasion on the back of his head at a local emergency department and the area on his head had "about	D 451		

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D 451	Continued From page 18	D 451		

healed up."

Review of Resident #2's Incident Report dated 09/24/19 revealed:
-Resident #2 "lost his footing and fell."
-Resident #2 "hit the back of his head."
-The fall resulted in a scrape and skin tear to the back of the resident's head.
-Facility staff notified emergency medical services and the resident was transported to the local emergency department for evaluation.
-There was not an area on the form for staff to document notification of the local department of social services.

Review of Resident #2's emergency department home instructions dated 09/24/19 revealed:
-The resident was evaluated for minor head injury with no loss of consciousness due to a mechanical fall and for acute cervical strain.
-A head computed tomography (CT) scan was completed.
-The indications for the CT scan of the head was due to age 65 or greater and currently taking anticoagulants.

Interview with a medication aide (MA) on 10/03/19 at 10:02am revealed:
-Resident #2 had fallen on 09/24/19.
-Resident #2 had hit his head during the fall and was bleeding from an area on the back of his head.
-She had sent Resident #2 to the emergency department for evaluation.
-The medication aide was responsible for filling out an incident report whenever a resident was sent to the emergency department for evaluation.
-She had filled out the incident report dated 09/24/19.
-Once the incident report had been filled out, she

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D 451	Continued From page 19	D 451		

had been trained to give the report to the Administrator.
-She had given the incident report dated 09/24/19 to the Administrator.
-She had not faxed the incident report to the local department of social services.
-She did not know if the incident reports were faxed to the local department of social services once they were given to the Administrator.

Interview with a representative from the local county department of social services on 10/03/19 at 10:40am revealed he had not received a copy of Resident #2's incident report dated 09/24/19.

Interview with the Administrator on 10/03/19 at 4:45pm revealed:
-The incident report for Resident #2 dated 09/24/19 should have been faxed to the local department of social services by the medication aide who had filled out the report "by the end of their shift."
-If a resident sustained an injury and required being sent to the emergency department for evaluation then it should have been sent to the local department of social services within 24 hours.

2. Review of Resident #1's current FL2 dated 06/27/19 revealed:
-Diagnoses included mild cognitive impairment, hypertension, chronic back pain, and osteoporosis.
-The resident was documented as ambulatory, intermittently disoriented, and incontinent of bowel.

Interview with Resident #1 on 10/02/19 at 9:15am revealed:
-The resident had resided at the facility for one

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D 451	Continued From page 20	D 451		

year.
-The resident had bad balance and a history of falls.
-The resident had fallen that morning (10/02/19).

Review of Resident #1's Incident Report dated 01/23/19 revealed:
-Staff heard the resident "crying and yelling."
-The resident was found "holding her arm" and had fallen trying to put on pajamas.
-The facility called emergency medical services and the resident was taken to the emergency department for evaluation.
-There was not an area on the form for staff to document notification of the local department of social services.

Interview with a medication aide (MA) on 10/03/19 at 10:02am revealed:
-The medication aide was responsible for filling out an incident report whenever a resident was sent to the emergency department for evaluation.
-Once the incident report had been filled out, she had been trained to give the report to the Administrator.
-She did not know if the incident reports were faxed to the local department of social services once they were given to the Administrator.

Interview with a representative from the local county department of social services on 10/03/19 at 10:40am revealed he had not received a copy of Resident #1's incident report dated 01/23/19.

Interview with the Administrator on 10/03/19 at 4:45pm revealed if a resident sustained an injury and required being sent to the emergency department for evaluation then the incident report should have been faxed to the local department of social services within 24 hours.

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D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to assure residents received care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules related to staff qualifications and medication administration. The findings are: 1. Based on record reviews and interviews, the facility failed to ensure at least one staff member was on the premises at all times who had completed within the last 24 months a course on Cardio-Pulmonary Resuscitation (CPR) and choking management for 2 of 3 sampled staff (Staff B and C) for 2 of 10 shifts sampled for the week of 09/29/19 to 10/03/19.[Refer to Tag 0167, 10A NCAC 13F .0507 Training On Cardio-Pulmonary Resuscitation (Type B Violation)]. 2. Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered and in accordance with the facility's policies for 1 of 3 sampled residents	D912		

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D912	Continued From page 22 (Resident #2) including errors in anticoagulation medication and insulin. [Refer to Tag 0358, 10A NCAC 13F .1004(a) Medication Administration (Type B Violation)].	D912		